MHSOAC
MENTAL HEALTH SERVICES
OVERSIGHT AND ACCOUNTABILITY COMMISSION

CULTURAL & LINGUISTIC COMPETENCE TECHNICAL RESOURCE GROUP (CLCTRG) DRAFT WORKPLAN

Introduction

Cultural and linguistic competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among consumer providers, family members, and professionals that enable that system, agency or those providers to work effectively in cross-cultural situations. (Source: Adapted from Cross, T.L., Bazron, B.J. Dennis, K.W., Issacs, M.R.and Benjamin, M.P. (1989). Towards A Culturally Competent System of Care, (Vol) Washington, D.C.

There are Five Essential Elements of Cultural Competence:

Cultural

1. Valuing Diversity
2. 2. Cultural Self Assessment
3. Dynamics of Differences
4. Institutionalization of Cultural Knowledge
5. Adaptation to Diversity

The Mental Health Services Oversight and Accountability Commission (MHSOAC) adopted an eighteen-month plan in November 2006. In this plan, the MHSOAC restructured all MHSOAC Committees in order to effectively address the Commission's statutory mandates. The MHSOAC 2007-2008 Work Plan adopted three *Committees*: (1) Community Services and Supports/Capital and IT, (2) Innovation and Prevention/Early Intervention, and (3) Education and Training. It also adopted three *Technical Resource Groups:* (1) **Cultural and Linguistic Competence**, (2) Client and Family, and, (3) Outcome and Measurements.

The primary role of MHSOAC Technical Resource Groups is to ensure the MHSOAC has access to experts in the three core principles of the Act: cultural and linguistic competence to reduce disparities, client and family involvement in shaping MHSA policy, and outcomes accountability. The CLCTRG serves at the pleasure of the Commission. It will consist of individuals with expertise in a systems approach to cultural and linguistic competence, mental health stigma and discrimination reduction, and the reduction of disparities in access to, quality of, and mental health outcomes among unserved / underserved / inappropriately served communities in California. The CLCTRG will at a minimum consist of individuals with knowledge and experience in the mental health field and include stakeholders from California's diverse populations including but not limited to: the Department of Mental Health , Office of Multicultural Services (DMH, OMS), the California Institute for Mental Health, Center for Multicultural Development (CIMH, CMD), the California Mental Health Directors Association, Cultural Competence/Ethnic Service Managers (CMHDA, CC/ESM), the University of California, Davis, Center for Reducing Health Disparities (UCD, CRHD), and California Network of Mental Health Clients (CNMHC), the Mental Health Association in California (MHAC), the National Alliance on Mental Illness (NAMI), and United Advocates for Children and Families (UACF). Efforts will be made to have representatives from different ethnic, racial, and cultural groups. CLCTRG members will serve a two-year rotating term.

* - See Glossary, page 4

THE CHARGE OF THE CLCTRG

The Cultural and Linguistic Competence Technical Resource Group (CLCTRG) is charged with ensuring that the Commission has an ongoing focus in the area of access, quality, and outcomes disparities in mental health service provision to unserved / underserved / inappropriately served communities with historical disparities. *Historical disparities are defined as California's racial-ethnic populations including African-Americans, Latinos, Asian Pacific Islanders (API), and Native American as these groups have demonstrated evidence of historical disparities in access and appropriateness of care in mental health systems. In addition, to populations with historical disparities, this group should include rural communities, California's elderly population and as appropriate the GLBTQ community. *Historical disparities are defined here to first include and to begin with those defined groups as they have evidence of disparities in mental health services. Any other Group targeted by a county must be clearly defined with demonstrated evidence and supporting data to target them as having historic disparities in mental health services.

Several major framework themes can be used for the Unserved / Underserved / Inappropriately Served population definition:

1. Those that are receiving some level of assistance but not adequate to deal with their mental illness.

2. Those groups that are not represented in treatment data equal to their presence in the general population.

3. Those populations that have not been historically provided access to mental health services.

4. Those that are not represented in data systems reporting treatment for mental illness.

THE FOUR PRIMARY ROLES OF THE CLCTRG

1. Provide Information and Technical Assistance to Commissioners to assist them in achieving their goal of reducing disparities in access to, quality of and outcomes of mental health services.

- Provide the MHSOAC Staff and Commissioners with assistance in the development of a vision for disparities elimination, as well as a plan with benchmarks to work toward the reduction of disparities.

- Provide MHSOAC Staff and Commissioners with advice and counsel to ensure MHSOAC meetings demonstrate cultural honoring, cultural responsiveness, and *cultural humility.

2. Assist Commissioners in creating accountability mechanisms for reduction of disparities.

- Assist Commissioners in developing strategies to ensure counties and the state are accountable for reduction of disparities in their quality of mental health care for historically unserved/underserved cultural, racial and ethnic populations.

- Assist the Commission in the development of mechanisms that provide historically unserved/underserved populations a path to involvement in mental health policy development

* - See Glossary, page 4

- Assist Commissioners in developing their capacity to implement culturally appropriate outreach and engagement models for California's historically unserved/underserved communities.

3. Recommend that historically unserved/underserved communities are involved in mental health policy development.

4. Provide a Public Forum where unserved / underserved / inappropriately served groups can raise concerns, issues and policy questions related to the reduction of disparities in California's public mental health system.

    - Serve as a referral source for Commissioners when issues related to disparity are identified at Commission meetings.

    - Serve as an initial access point to the MHSOAC, if desired by communities, where historically unserved/underserved can identify concerns related to MHSA planning or implementation.

    - Support engagement of historically underserved communities and encourage their participation at MHSOAC meetings, particularly when there are agenda items related to reducing disparities in California's mental health service system.

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TIMELINE FOR THE CLCTRG

The CLCTRG will meet monthly including the day before the full OAC meetings. The monthly meetings will begin August 2007. The-Meeting Dates:

Aug 22	Oakland/Sacramento
Sept 26	Sacramento
Oct 24	TBA
Nov.14	Redding
Dec	No Meeting

Meetings will be held from 10am to 2pm.

PROCESS/ RESOURCES

In order to assist MHSOAC Commissioners, the CLCTRG will need to collaborate through both expert presentations as well as public testimony. Staff will initiate the planning and design of necessary meetings and/or public hearings and will ensure that the CLCTRG is informed prior to establishing a final CLCTRG workplan for the MHSOAC. Staff will keep CLCTRG members informed and solicit input and participation in such meetings and/or public hearings.

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Glossary

Adopted Definitions by the CLCTRG

Historical Disparities:

Historical disparities are defined as California's racial-ethnic populations including African-Americans, Latinos, Asian Pacific Islanders (API), and Native American, as these groups have demonstrated evidence of historical disparities in access and appropriateness of care in mental health systems. These are the unserved/ underserved and inappropriately served populations with historical disparities. Additionally, this should also include rural communities, California's elderly population and as appropriate the GLBTQ community.

Historical disparities are defined here to first include and to begin with those defined groups as they have evidence of disparities in mental health services. Any other 'Group' targeted by a county must be clearly defined with demonstrated evidence and supporting data to target them as having "historic disparities in mental health services."

Cultural Humility:

A process that requires humility as individuals continually engage in self-reflection and self-critique as lifelong learners and reflective practitioners, it requires humility in how health practioners bring into check the power imbalances that exist in the dynamics of practioner-patient communication by using patient-focused interviewing and care, and it is a process that requires humility to develop and maintain mutually respectful and dynamic partnerships with communities. The cultural humility approach enhances patient care by effectively weaving an attitude of learning about cultural differences into patient encounters. Additionally, this approach cultivates self-awareness by encouraging health practioners to acknowledge the belief systems and cultural values they bring to patient encounters

* - See Glossary, page 4